

ORIGINAL

IN THE SUPREME COURT OF OHIO
Case No. 2010-1236

ON APPEAL FROM THE COURT OF APPEALS
SIXTH APPELLATE DISTRICT
LUCAS COUNTY, OHIO
CASE NO. L-09-1282

VIRGINIA KING
Plaintiff-Appellee

v.

PROMEDICA HEALTH SYSTEM AND THE TOLEDO HOSPITAL
Defendants-Appellants

MEMORANDUM OPPOSING JURISDICTION OF APPELLEE VIRGINIA KING

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I. EXPLANATION OF WHY THIS CASE IS NOT OF GREAT PUBLIC OR GENERAL INTEREST

Appellants and their *amici* work to create uncertainty and conflict where none exists. Ohio's appellate courts agree that the meaning of R.C. § 1751.60 is unambiguous: after attracting patients by agreeing to "accept" the reasonable, reliable and negotiated payment from their health insurers, hospitals and other health care providers cannot turn around and try to capitalize on other, often limited, resources available to those same patients. The appellant health-care provider cannot seize its patient's contractual right to her own automobile insurance benefits.

Appellants nonetheless ask this Court to accept discretionary jurisdiction and overturn existing law so that they may continue a practice rejected by every single Ohio appellate court to examine it. The billing practices at issue here unlawfully enrich health care providers at the expense of Ohioans who have paid dearly for private health insurance.

Private health insurers maintain a system of "preferred providers." Generally, the preferred provider negotiates to accept a specific payment for medical services at a rate agreed between itself and the contracting health insuring corporation. For patients with health insurance, this arrangement benefits all involved. The preferred provider gains access to a pool of patients enrolled in plans offered by health insuring corporations. In turn, the health insurer and its subscribers secure medical services at a discount from the full "retail" amount demanded from the few patients who are: 1) not insured; and 2) able to pay for medical services from their own pocket. In the real world almost nobody actually pays the "retail" price for medical services and even fewer do so knowingly.

Having entered into this bargain, preferred providers have an incentive to seek other, more lucrative, sources of payment. In particular, health care providers are financially motivated to stick a patient, liability insurer or a third-party tortfeasor with a bill for the full, undiscounted

(and often inflated) “retail” price for medical services -- a sum invariably well above the amount that the preferred provider previously bargained for.

By enacting R.C. § 1751.60(A), Ohio’s legislature has unequivocally prohibited this practice. The statute provides, in pertinent part:

Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation’s enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

Despite the clear mandate of R.C. § 1751.60 to seek compensation “solely” from the patient’s health insuring corporation, Appellants argue that they are somehow entitled to bill someone else.

As set forth below, the only two appellate courts to address the issue have squarely concluded that statute means what it says: preferred providers may bill only the health insuring corporation.¹ At least one additional appellate court has adopted this view in *dicta*.² Appellants and their *amici* nonetheless suggest that this Court must accept jurisdiction and overturn the emerging consensus in the appellate courts for two dubious reasons.

First, Appellants argue that the accepted construction of R.C. § 1751.60 cannot be reconciled with Ohio’s scheme for coordination of benefits. Appellants fail to mention, however, that the two statutes address different topics. Revised Code § 1751.60 governs the entities that a preferred provider may bill for covered services. In contrast, the coordination of benefits scheme governs the manner that multiple health insurers determine which policy is

¹ *Hayberg v. Physicians Emergency Serv. Inc.*, 11th Dist. No. 08-P-0010, 2008-Ohio-6180; *King v. ProMedica Health Systems, Inc.*, 6th Dist. No. L-09-1282, 2010-Ohio-2578

² *McArthur v. Randall*, 166 Ohio App.3d 546, 2006-Ohio-777 at ¶¶ 5-6, 14.

“primary,” or responsible for paying first. To be clear, the coordination of benefits rules cited by Appellants do not require health providers to bill, or refrain from billing, anyone.

Second, Appellants and their *amici* nakedly assert that violations of R.C. § 1751.60 are so widespread, in fact “common industry practice,³” that compliance with the statute would be unreasonably burdensome. True or false, this argument should make no difference. There can be no question that the legislature has the power to prohibit unscrupulous health-care billing practices, even well established ones.

Because Ohio appellate courts already agreed about the meaning of the plain language enacted by the legislature, this Court need not accept discretionary jurisdiction in this matter as no question of great public interest exists.

II. STATEMENT OF THE CASE AND OF FACTS

A. Statement of Facts: Appellants directly billed Appellee’s automobile insurer for services covered by her health insuring corporation.

Although the essential facts leading to this action are not meaningfully in dispute, significant details remain undeveloped because the trial court prematurely granted a motion to dismiss pursuant to Civ.R. 12(B)(6).

After being injured in an automobile accident, King sought treatment at the Toledo Hospital, which is operated by Appellant ProMedica Health System. King was a subscriber to a health insurance plan issued by Aetna. At time of her admission, King provided hospital staff with all information necessary to submit a claim to her health insurer. Appellants nonetheless directly billed King’s automobile insurer, Safeco, for the medical payments benefits available under that policy. This much is essentially undisputed.

³ See Memorandum of Amici Curiae, Ohio Hospital Association, Ohio State Medical Association, and Ohio Osteopathic Association, in Support of ProMedica Health System, Inc.’s Memorandum in Support of Jurisdiction at p. 7.

Because the trial court disposed of the case at an early stage, no factual record is available. The Aetna and Safeco policies are not available for review, nor are any contracts between Appellants and either insurer. Important specifics about the manner with which appellants billed King's insurer are not in the record. At this stage of the litigation, the Court must accept the allegations in King's complaint that Appellants billed her automobile insurer to the exclusion of her health insurer.⁴ (See Cmplt. at ¶ 16).

B. Procedural History: The Sixth District reversed the trial court's dismissal of Appellant's complaint.

This request for review flows from the second incarnation of this litigation. King first filed this action in the United States District Court in November 2008. In March 2009, King voluntarily dismissed the federal action when questions arose regarding that court's subject matter jurisdiction.

In April 2009, King re-filed the action in the Lucas County Court of Common Pleas and Appellants moved to dismiss. Relying largely on the dissenting opinion in the Eleventh District's *Hayberg* decision, the trial court dismissed King's complaint, concluding that even under R.C. § 1751.60 Appellants are permitted to bill third-party payers. King appealed and the Sixth District reversed, holding that R.C. § 1751.60 prohibited preferred providers from doing exactly that. *King v. ProMedica Health Systems, Inc.*, 6th Dist. No. L-09-1282, 2010-Ohio-2578. The Sixth District decision was aligned with the majority in *Hayberg*. Now, two appellate districts have reviewed the issue and reached essentially identical conclusions.

Appellants seek discretionary review of the Sixth District's decision.

⁴ Based the information exchanged in limited discovery before the trial court granted the motion to dismiss, King now understands that Appellants may have billed and received compensation from *both* of her insurers. It also appears that a refund may have been issued to her health insurer, as was the case in *Hayberg*. The circumstances surrounding the sequence of billing and any refund are not fully developed at this point in the litigation.

III. LAW AND ARGUMENT

A. Response to Proposition of Law No. 1: The Sixth District properly interpreted R.C. § 1751.60 because “solely” means solely.

The Sixth District, along with the Eleventh, determined that R.C. § 1751.60 unambiguously prohibits hospitals and other providers from circumventing their preferred provider agreements by billing other third-party providers that may be ultimately responsible for payment. There is no reason for this Court to disturb this developing consensus.

1. The plain and ordinary meaning of every word of R.C. § 1751.60 must be given effect before the Court turns to external rules of statutory interpretation.

The various alternative interpretations of R.C. § 1751.60 advocated by Appellants and their *amici* simply cannot be reconciled with the words of the statute without disregarding substantial portions of its actual language. This result would be contrary to well-established rules of statutory construction.

When construing a statute, a court’s paramount concern is the legislature’s intent in enacting it. See, e.g., *State ex rel. Cincinnati Enquirer v. Jones-Kelly*, 118 Ohio St.3d 81, 2008-Ohio-1770 at ¶ 17; *State ex. Rel. Russell v. Thornton*, 111 Ohio St.3d 409, 2006-Ohio-5858 at ¶ 11. “The court must look to the statute itself to determine legislative intent, and if such intent is clearly expressed therein, the statute may not be restricted, constrict, qualified, narrowed, enlarged or abridged; significance and effect should, if possible, be accorded to every word, phrase, sentence and part of an act.” *State ex. rel. McGraw v. Gorman* (1985), 17 Ohio St.3d 147, 149, quoting *Wachendorf v. Shaver* (1948), 149 Ohio St. 231, paragraph five of the syllabus. “In construing the terms of a particular statute, words must be given their usual, normal, and/or customary meanings.” *Proctor v. Kardassilaris*, 115 Ohio St.3d 71, 2007-Ohio-4838 at ¶ 12.

A court cannot turn to other principles of statutory interpretation until it exhausts the plain meaning of the words actually in the statute. When the plain language is clear and has a definite meaning, there is no need to apply rules of statutory construction. *Id.*; see also *Cline v. Ohio Bur. Of Motor Vehicles* (1991), 61 Ohio St.3d 93, 96.

Without looking further, these fundamental principles of statutory construction compel the conclusion that R.C. § 1751.60 prohibits a health care provider from seeking compensation from entities other than the patient's health insurer. To do otherwise would render portions of the statute meaningless. The Sixth District properly found that the phrase "shall seek compensation for covered service solely from the health insuring corporation" could not be clearer. If a health care facility provides covered services to an enrollee/subscriber, it must seek compensation "solely" from the health insurer, as opposed to all others. *King v. ProMedica Health Systems, Inc.*, 6th Dist. No. L-09-1282, 2010-Ohio-2578 at ¶ 12.

2. Ohio's appellate courts are in agreement about the meaning of R.C. § 1751.60.

Each of the appellate courts presented with the issue have concluded that R.C. § 1751.60 prohibits the billing practices at issue here. The Sixth and Eleventh Districts unambiguously held that the statute applies to billing third party payers. In *dicta*, the Second District has also adopted the same view. No appellate district has held otherwise. In this sense, Appellants' suggestion that the law on this issue is crying out for clarification is unfounded.

In *Hayberg*, the Eleventh District held that the statute's requirement to bill the patient's health insurer for covered services included a prohibition against billing other third-party payers. *Hayberg*, 2008-Ohio-6180 at ¶ 26. In *Hayberg*, Robinson Memorial Hospital initially billed a patient's health insurer (Anthem) a total of \$11,295.39 for a patient's treatment. *Id.* at ¶ 3. Upon learning that the patient's auto insurer (Nationwide) was responsible for her medical bills, the

hospital billed Nationwide \$13,861.45 for the same services and provided Anthem a refund. *Id.* at ¶¶ 3-4. The *Hayberg* court concluded that the hospital “billed and accepted \$2,566.06 more than it was entitled to from Nationwide in violation of R.C. § 1751.60. Under the statute [the hospital] was required to seek compensation solely from Anthem and was only permitted to seek approved co-payments and deductibles... from Nationwide.” *Id.* at ¶ 26.

The *Hayberg* court noted that the “clear legislative purpose of R.C. § 1751.60 is to make sure that individuals who are covered under health plans realize the benefits of those plans and are not forced to pay any amount in excess of the copayments and deductibles they are required to pay under the contracts between health care facilities and health insuring corporations.” *Id.* at ¶ 25. The court observed that the hospital, by collecting \$2,566.06 more from Nationwide than it would have received under its contract with Anthem, reduced the amount available to the patient/insured under the Nationwide policy. *Id.* at ¶ 43. In other words, the provider took \$2,566.06 directly out of its patient’s pocket in violation of R.C. § 1751.60.

In *dicta*, the Second District agreed, holding that R.C. § 1751.60 prohibited a chiropractor from billing an Anthem enrollee⁵ for anything other than approved co-payments or uncovered services. *McArthur v. Randall*, 166 Ohio App.3d 546, 2006-Ohio-777 at ¶ 14. The *McArthur* court reached this conclusion despite the chiropractor’s testimony that he bypassed the health insurer, in part, because he believed that an automobile insurer would ultimately be responsible for the patient’s medical bills. *McArthur*, 2006-Ohio-777 at ¶¶ 5-6.

Finally, it is worth noting that no appellate district agrees with any of alternative constructions of R.C. 1751.60 offered by Appellants and their *amici*. Contrary to the picture painted in the various briefing seeking discretionary review, Ohio law is fairly settled on the

⁵ The primary disputed issue in *McArthur* is whether the chiropractor was, in fact, an Anthem “preferred provider” at the time of treatment. *Id.* at ¶¶ 22-23

issue. Although Appellants may not like the restrictions on their billing practices established by R.C. § 1751.60, they are not faced with conflicting duties, confusing law or anywhere near the level of chaos about which they complain. The law is reasonably clear if Appellants and their *amici* wish to follow it.

3. *Appellants and their amici cannot agree what conduct, exactly, is prohibited by R.C. § 1751.60.*

Unsatisfied with clear statutory language and unanimous existing appellate authority, Appellants and their *amici* posit at least two alternate meanings of R.C. § 1751.60. Neither can be reconciled with the language of the statute or, for that matter, each other.

Appellants themselves advocate construing R.C. § 1751.60 as “applying only when the coverage afforded by the Health Insuring Corporation is the only coverage available to the patient. In other words, if there is no other coverage at all or all other coverage has been exhausted, and the Health Insuring Corporation and the insured patient are the only remaining available payers, [Appellants] may seek compensation only from the Health Insuring Corporation and not from the insured patient.”⁶

In contrast, the Ohio Hospital Association, *et. al*, suggest that R.C. § 1751.60 is only implicated when the patient’s health insurer is insolvent. “[U]nder R.C. 1751.60, if a health insuring corporation becomes insolvent or for some other reason does not pay the medical provider for covered service, the medical provider cannot seek payment from the enrollee *** [the statute] should only be invoked under that circumstance.”⁷

⁶ See Memorandum in Support of Jurisdiction of Appellants ProMedica Health System and The Toledo Hospital at p. 7.

⁷ See Memorandum of Amici Curiae, Ohio Hospital Association, Ohio State Medical Association, and Ohio Osteopathic Association, in Support of ProMedica Health System, Inc.’s Memorandum in Support of Jurisdiction at p. 8.

The disagreement about the “obvious” alternate meaning of R.C. § 1751.60 clearly illustrates the danger of disregarding the text of a legislative enactment in favor of a results-driven policy analysis disguised as “principles of statutory interpretation.” Even if, as Appellants suggest, the clear language of R.C. § 1751.60 places an unreasonable burden on hospitals and other health care providers, the proper forum for redress is the General Assembly. Unless and until the statute is actually amended, “solely” means solely.

B. Response to Proposition of Law No. 2: Ohio’s coordination of benefits rules impose no duties on health care providers and do not conflict with R.C. § 1751.60.

1. Appellants do not identify any bona fide conflict between the Sixth District’s construction of R.C. § 1751.60 and Ohio’s coordination of benefits scheme.

Despite Defendants’ assertions to the contrary, Ohio’s coordination of benefits rules do not conflict with R.C. § 1751.60. Further, Defendants have not pointed to any instance where the coordination of benefits scheme requires *them* to bill an entity other than King’s health insurer.

The coordination of benefits rules apply to health insurers and health insurance plans, not facilities and providers. A cursory reading of the coordination of benefits statute, R.C. § 3902.11, *et seq.*, shows that the statute is not an all-inclusive scheme governing the complex relationship between tortfeasors, insureds, health insuring corporations, automobile insurers and health care providers. Instead the coordination of benefits statute focuses on resolving conflicts among insurance policies held by the same person or by different members of the same family. Much of the statute is dedicated to resolving conflicts arising when a dependent is covered by more than one policy. See R.C. § 3902.13(A)(3) and (A)(4). Appellants have not explained how the coordination of benefits rules excuse their responsibility, as health care providers, to comply with R.C. § 1751.60 and bill “solely” King’s health insuring corporation.

The administrative rules governing the coordination of benefits contain an even clearer statement of purpose. The rules are intended to, among other purposes: “Provide the authority for an orderly transfer of information needed to pay claims promptly” (OAC 3901-8-01(B)(2)) and “reduce payment delays” (OAC 3901-8-01(B)(3)). Importantly, the coordination of benefit rules are intended to “[e]liminate duplication of benefits by permitting a plan to reduce benefits paid, when, pursuant to this rule, it is not required to pay benefits first.” The rules explicitly address the plan’s ability to coordinate benefits and do not authorize providers to bill particular plans. This is consistent with King’s position that Appellants should not be able to recover additional funds from another payer when her health insurer was clearly identified and stands ready to compensate Appellants based on rates negotiated between themselves and King’s Health Insuring Corporation.

When read together, R.C. § 1751.60 and the coordination of benefits rules are entirely consistent. Pursuant to R.C. § 1751.60, health care providers are required to bill the patient’s health insuring corporation. The health insurer, applying the coordination of benefits rules, may then determine whether another insurer is ultimately liable for the cost of a patient’s care.

2. *The “coordination of benefits” argument advanced by Appellants is a convenient vehicle for directly violating R.C. § 1751.60.*

Appellants’ invocation of Ohio’s coordination of benefits scheme is the reddest of herrings. In their briefing in support of jurisdiction, Appellants and their *amici* essentially admit that the coordination of benefits rules play no role in their billing practices because they make absolutely no effort to actually identify the “primary” payer under the scheme. Instead, Appellants seek to identify and indiscriminately bill any entity might pay. In fact, Appellants and their *amici* systematically reject any responsibility for actually applying the coordination of benefit rules.

As Appellants' *amici* acknowledge, in their view, "**** hospitals and doctors are not required to determine which coverage should pay first or how much each should pay. In fact, this would be virtually impossible for them to do since they usually have only limited, general information pertaining to potential coverage."⁸ Appellants' solution is something of a shotgun approach to patient billing: methodically identifying all potential third-party payers and then arbitrarily billing some, or all, of them and accepting payment from the most lucrative option.⁹ To be clear, providers are not offering to act as fiduciaries of their patients and working to maximize the insurance benefits available under all plans.

Instead, they are shopping for the maximum possible payment for the same services, often directly at the expense of the patient. Every dollar that a preferred provider collects directly from the medical payment portion of an automobile policy is a dollar that the patient cannot use to pay deductibles, co-payments or other obligations. In the case of third-party tortfeasor's liability policy, every dollar that is seized by the preferred provider and applied toward the inflated "retail" markup of health care services is a dollar that could have been used to meet other needs. Because many liability policies do not contain nearly enough coverage¹⁰ for the cost of an injury, the patient is often left without complete relief.

This issue, then, comes down to whether Appellants and other health-care providers can hijack contractual benefits purchased by King and other Ohioans who have paid for both health

⁸ See Memorandum of Amici Curiae, Ohio Hospital Association, Ohio State Medical Association, and Ohio Osteopathic Association, in Support of ProMedica Health System, Inc.'s Memorandum in Support of Jurisdiction at p. 7.

⁹ Consider the facts in *Hayberg*. The hospital initially received payment from the patient's health insurer, but then went out of its way to collect an additional amount from her automobile insurer. *Hayberg*, 2008-Ohio-6180 at ¶¶ 3-4.

¹⁰ At present state minimum automobile liability coverage is \$12,500 per person and \$25,000 per accident: not enough to meet the financial needs of a victim of an even moderately serious accident.

and automobile insurance. The legislature enacted R.C. § 1751.60, in part, to protect existing contractual expectations among the providers, insurers and patients. By billing the patient's health insurer, the provider receives exactly the payment that it bargained for. In contrast, providers have no right, contractual or otherwise, to directly bill a patient's automobile insurer. The patient/policyholder has paid for their automobile policy and, therefore, controls the use of those benefits.

Appellants disingenuously argue that Ohio's automobile policy holders "will not be permitted to use their medical payments benefits to pay for the cost of medical services, and the automobile insurance companies will have sold their insured a benefit that they will not be able to use."¹¹ This argument gets the situation exactly backward. Under the prevailing interpretation of R.C. 1751.60 adopted by the Sixth District, King can choose to use her medical payment benefits to pay Appellants' medical bills, other medical bills which may not be covered under her health plan, co-payments and deductible, or anything else permitted by the contract between herself and her automobile insurer. This choice is exactly what King paid for when she purchased her automobile policy.

Appellants are not party to King's automobile insurance contract. Further, Appellants and their *amici* acknowledge that they do not have access to the terms of King's automobile insurance policy. Appellants nonetheless would like to jump in line ahead of all other possible uses for the medical payments benefits, regardless of what King and her automobile insurer have actually contracted.

¹¹ See Memorandum in Support of Jurisdiction of Appellants ProMedica Health System and The Toledo Hospital at p. 4.

IV. CONCLUSION

For the reasons set forth above, this court should decline to exercise discretionary jurisdiction in this case. The consensus interpretation of R.C. § 1751.60 developed in the appellate courts provides critical protection to Ohio's patients from a particularly harmful billing practice. Further the Sixth District's opinion is correctly rooted in the plain language adopted by the legislature. "Solely" means solely.

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